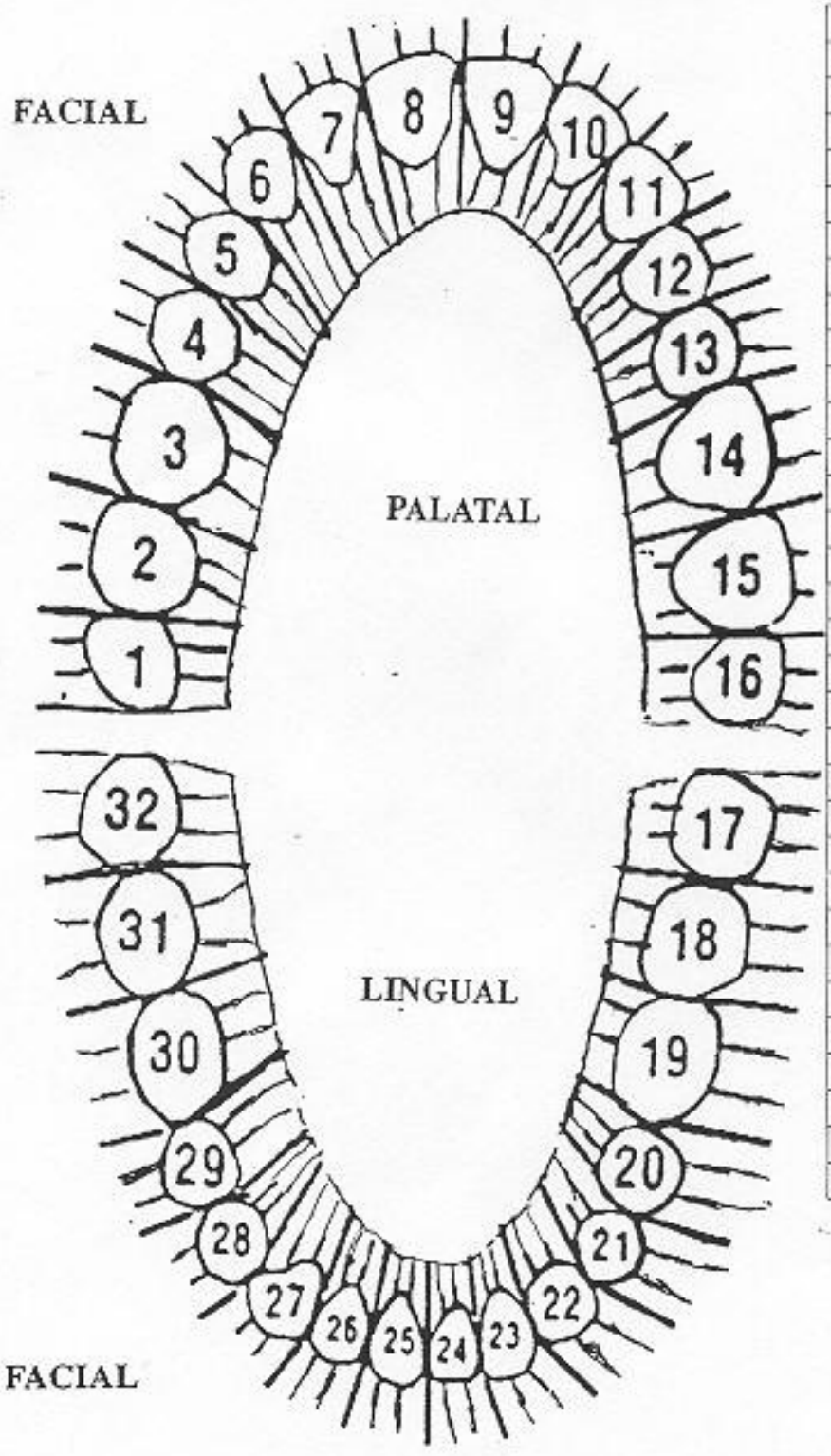
INDIANA STATE BOARD OF DENTISTRY
DENTAL HYGIENE EXAMINATION CHARTING FORM

Date _____ Procedure _____ Candidate # _____

COMPLETE PRIOR TO EXAMINATION

With a red pencil, mark out missing teeth with an "X" on chart below. Also indicate the depth of the periodontal pockets or the sulcus in the spaces corresponding to the appropriate surfaces on the chart below, but only include pocket depths ≥ 4 mm. On the chart to the right, in **column 1,** indicate existing restorations by surface. (I.E. #5- DO, #10-ML). In **column 2,** note any supernumeraries, impacted and deciduous teeth.



Tooth #	1	2
1		
2		
3		
4		
5		
6		
7		
8		
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11		
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INDIANA STATE BOARD OF DENTISTRY
MEDICAL AND DENTAL HISTORY FORM

Candidate ID # _____ Examination date _____

Patient Information

Name _____ Age _____ Birth date _____ Sex M F

Address _____

_____

Home phone _____ Business phone _____

Occupation _____ Employer _____

In case of emergency, notify: _____ Phone _____

Spouse, parent, or guardian _____ Address _____

Physician _____ Address _____ Phone _____

What is your present health? Good _____ Fair _____ Poor _____ Are you having pain or discomfort at this time? No ___ Yes ___ Has there been any change in your general health in the past year? If so, please explain _____

Circle any of the following that you have had or have at present:

Heart Condition	Bleed Easily	Skin Rashes or Hives	Thyroid Disease
Heart Attack or Stroke	Anemia/Hemophilia	Kidney Trouble	Cortisone medicine
Heart Murmur	Shortness of Breath	Diabetes	Glaucoma
HIV Positive/AIDS	Chest Pains(angina)	Swelling of ankles	Sickle Cell Disease
Arthritis/Rheumatism	Venereal Disease	Heart Surgery	Genital Herpes
Liver Disease	Pain in Jaw	Artificial Heart Valve	Lung Disease
Hepatitis A (infectious)	Fainting or Dizzy Spells	Cold sores	Heart Pacemaker
Emphysema	Hepatitis B (serum)	Alcoholism	Epilepsy or Seizures
High Blood Pressure	Tuberculosis (TB)	Yellow Jaundice	Drug Addiction
Psychiatric Treatment	Rheumatic Fever	Asthma or Hay Fever	Blood Transfusion
Sinus problems	Prolapsed mitral valve	Ulcers	Chronic Cough
JointsArtificial	Joint Replacement	Radiation Therapy (x-ray, cobalt)	
Chemotherapy(cancer, leukemia)		other contagious infections _____	

Date of last dental visit: _____ Reason _____

Date of last dental radiographs _____Date of last Prophylaxis _____

Clinical Examination: Circle any of the following areas that display problems or abnormal conditions and comment on pertinent findings.

1. General appearance 2. Head and neck 3. TMJ 4. Lips 5. Buccal Mucosa

6. Palate 7. Oropharynx 8. Floor of mouth 9. Tongue 10. Periodontium 11. Dentition (defects other than caries) 12. Occlusion 13. Oral Hygiene 14. Other findings

_____

_____

_____

_____

_____

Draw location of any pertinent lesions, etc.

When was your last physical examination? _____What were the findings?

_____

Do you have any diseases, conditions or problems that we should know about? ___if so, explain

_____ Circle

Are you presently taking any medicine or drugs? No Yes

If yes, list drug, dosage and frequency _____

Are you allergic to any medicine, drug or other substance? No Yes

Are you allergic to any medicine, drug or other substance? No Yes

If yes, please list _____

Are you now, or have you been under the care of a medical doctor during the last two years? No Yes

Have you ever been hospitalized or had surgery? No Yes

Have you ever had complications or illness following dental treatment? No Yes

Have you ever had an injury or trauma to your face or jaw? No Yes

Have you ever had abnormal bleeding associated with extractions, surgery, or teeth cleanings? No Yes

Have you had any serious illness _____ operation _____ or been hospitalized in the last five years? If so, what was the illness or problem? _____

Do you smoke or use smokeless tobacco? No Yes

Are you nervous or concerned about having dental work done? No Yes

Medical alert _____

Medical history summary: Review medical history with patient and comment on all pertinent findings.

_____

_____

Identify any restrictions in dental treatment for this patient _____

Disabled: Yes No If yes, circle all that apply: Medically Mentally (psychological or medical) Physically

Is a medical consult necessary? Yes No If a medical clearance is needed, a letter must be attached from the doctor. Is premedication required? Yes No If so, please record type(s) and dosage(s) of medication(s) administered. _____

_____

_____ _____

Signature of Patient **Date**